

# TAMARAK

23970 North Elm Road, Lincolnshire, Illinois 60069 (847) 634-3168 Fax 634-8262

## CAMPER HEALTH HISTORY/MEDICAL EXAM FORM

To be completed by parent/guardian and pediatrician and **must** be on file at camp **prior** to first day.

### Section A – To be completed by parent/guardian

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Camp \_\_\_\_\_

*Last First M.I.*

Gender: male  female

Home Address \_\_\_\_\_

*Street City State Zip*

#### General Questions

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness, or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever had back problems? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had problems with joints? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? .....                          | <input type="checkbox"/> | <input type="checkbox"/> | 17. Require an orthodontic appliance? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? .....                                | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any skin problems (e.g. itching, rash<br>acne)? .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have diabetes? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? .....                          | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have asthma? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? .....                   | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had mononucleosis in the past 12 month? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had problems with diarrhea/ constipation? .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? .....                | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have problems with sleepwalking? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out or became dizzy from exercise? ...    | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have a history of bed-wetting? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had seizures? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had an eating disorder? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had heart trouble? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had emotional difficulties for which<br>professional help was sought? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever been diagnosed with a heart murmur? .....        | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 14. Ever been diagnosed with a blood disorder? .....      | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

Please explain any "yes" answers, noting the number of the question and any other pertinent information?

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I authorize Tamarak Day Camp medical personnel to give the following over-the-counter medication(s) to my child as needed. Notification will be provided if dispensed.

	Yes	No		Yes	No
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (oral)	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil or Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	Benadryl (topical)	<input type="checkbox"/>	<input type="checkbox"/>
Tums	<input type="checkbox"/>	<input type="checkbox"/>	Neosporin	<input type="checkbox"/>	<input type="checkbox"/>

**Parent Guardian Authorizations:** This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted.

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_

### Section B – To be completed by physician (including back side)

Immunizations are current to date according to the Illinois Admin. Code no. 665?  Yes  No

Comments \_\_\_\_\_

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**Health Care Recommendations by Licensed Medical Personnel**

Participant Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Last First M.I.*

I have examined the above camp participant. Date of examination \_\_\_\_/\_\_\_\_/\_\_\_\_ BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

**The applicant is under the care of a physician for the following conditions** \_\_\_\_\_

**Current treatment at the time of this report includes** \_\_\_\_\_

**Recommendations and Restrictions at camp**

Treatment to be continued at camp \_\_\_\_\_

Any medical-prescribed meal plan or dietary restrictions \_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

Additional information for health care staff at the camp \_\_\_\_\_

**Food Allergies:**  Yes  No If, Yes, a "Food Allergy Action Plan" must be completed prior to camp.

**Medication Allergies (list)** \_\_\_\_\_

**Other Allergies (list) – insect stings, hay fever, asthma, etc. Include medications provided at camp office.**

**This person takes medication on a routine basis**  Yes  No

If "Yes", complete the following

Medication #1 \_\_\_\_\_ Dosage & Times day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Medication #2 \_\_\_\_\_ Dosage & Times day \_\_\_\_\_

Reason for taking \_\_\_\_\_

**Attach additional pages for more medications.**

**Identify any medications taken during the school year the participant does/may not take during the summer**

**Additional information about the participants behavior, physical, emotional, or mental health about which the camp should be aware.**

**Signature of Licensed Medical Personnel** \_\_\_\_\_ **Printed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_